Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

RECONSTRUCTIVE ORTHOPEADIC CENTER OF HOUSTON
4126 SOUTH WEST FREEWAY SUITE 330
HOUSTON TX 77027

Respondent Name

TEXAS MUTUAL INSURANCE CO

Carrier's Austin Representative Box

Box Number 54

MFDR Tracking Number

M4-11-3778-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "This medical bill was denied for no authorization. We send a request for pre authorization (attached) on 01/17/2011 and obtained a written authorization (attached) prior to the surgery for procedure 29827 and 29826 to be performed between the date of 01/21/2011 to 02/25/2011. Unfortunately patient had to reschedule the surgery date and we contracted TX Mutual and discuss this with adjuster Angie Balderas on 03/08/2011 and adjuster confirmed the authorization to be extended verbally and surgery was done on 03/24/2011."

Amount in Dispute: $5289.54

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Upon receipt of the billing Texas Mutual reviewed the bill and associated documents, noted the dates of the authorization, and then denied payment because the authorization was outside the approved dates." "The requestor argues it received verbal approval from Texas Mutual's benefit administrator for the 3/24/11 surgery date. Review of Texas Mutual's claim file, inclusive of diary notes, reflects no such verbal approval, nor does it reflect any contract by the requestor for that stated purpose."

Response Submitted by: Texas Mutual Insurance Co., 6210 E. Hwy.90, Austin, TX 78723

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 24, 2011	ASC Services for CPT Code 29827 and 29826	$5289.54	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §134.203, titled *Medical Fee Guideline for Professional Services*, effective March 1, 2008, sets the reimbursement guidelines for the disputed service.
3. 28 Texas Administrative Code §133.2, effective July 27, 2008, 33 TexReg 5701, defines a medical emergency.
4. 28 Texas Administrative Code §134.600, requires preauthorization for specific treatments and services.
5. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated April 29, 2011
   - CAC-B5-Coverage/Program guidelines were not met or were exceeded.
   - CAC-197-Precertification/Authorization/Notification absent.
   - 728-This bill was reviewed in accordance with your First Health Contract.
   - 786-Denied for lack of preauthorization or preauthorization denial in accordance with the Network contract.

   Explanation of benefits dated May 16, 2011
   - CAC-B5-Coverage/Program guidelines were not met or were exceeded.
   - CAC-193-Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
   - CAC-197-Precertification/Authorization/Notification absent.
   - 724-No additional payment after a reconsideration of services.
   - 728-This bill was reviewed in accordance with your First Health Contract.
   - 786-Denied for lack of preauthorization or preauthorization denial in accordance with the Network contract.

Issues

1. Did the requestor support position that disputed services were preauthorized? Is the requestor entitled to reimbursement?

Findings

1. The insurance carrier denied reimbursement for the disputed psychiatric interview, code 90801, based upon "CAC-197-Precertification/Authorization/Notification absent," and "786-Denied for lack of preauthorization or preauthorization denial in accordance with the Network contract" .

   28 Texas Administrative Code §134.600(p)(2) states "Non-emergency health care requiring preauthorization includes: (2) outpatient surgical or ambulatory surgical services as defined in subsection (a) of this section."

   28 Texas Administrative Code §134.600(f) states "The requestor or employee shall request and obtain preauthorization from the carrier prior to providing or receiving health care listed in subsection (p) of this section. Concurrent review shall be requested prior to the conclusion of the specific number of treatments or period of time preauthorized and approval must be obtained prior to extending the health care listed in subsection (q) of this section. The request for preauthorization or concurrent review shall be sent to the carrier by telephone, facsimile, or electronic transmission and, include the:
   (1) specific health care listed in subsection (p) or (q) of this section;
   (2) number of specific health care treatments and the specific period of time requested to complete the treatments."

   The respondent states in the position summary that "Upon receipt of the billing Texas Mutual reviewed the bill and associated documents, noted the dates of the authorization, and then denied payment because the authorization was outside the approved dates".

   A review of the preauthorization report indicates that the requestor obtained preauthorization approval for outpatient surgery for codes 29827 and 29826 with a start date of "1/21/11 and end date of 2/25/11".

   The requestor states in the position summary that "…we contracted TX Mutual and discuss this with adjuster Angie Balderas on 03/08/2011 and adjuster confirmed the authorization to be extended verbally and surgery was done on 03/24/2011."

   A review of the submitted documentation did not support the requestor's position regarding the preauthorization extension; therefore, reimbursement is not recommended for the disputed services.

Conclusion

The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, it is determined that the submitted documentation does not support the reimbursement amount sought by the requestor. The Division concludes that the requestor failed to support its position that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

		5/9/2012
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.